DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2007
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2007 JUL 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G179	A. BUILDING _____ B. WING _____	P 07/12/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES	5701 13TH STREET, NW WASHINGTON, DC 20011

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W 000	INITIAL COMMENTS A recertification survey was conducted from July 11, 2007 through July 12, 2007. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a resident population of four females with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with clients, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas: The finding includes: The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Front door bell alarm button loose; b. Back bedroom door bell alarm button loose; c. Missing towel bar in the first bathroom on the first floor; d. Missing towel bar in the second bathroom on	W 104	W 104 a. Front door bell has been fixed b. Back bedroom door bell has been fixed c. Towel bar replaced in the first BR d. Towel bar replaced in the second BR e. Missing globe light in laundry room has been replaced f. Broken Dryer has been removed g. Unused walkers were removed h. Broken chair removed i. Broken vacuum cleaner removed In the future the Agency will ensure that the facility's environment is well maintained and safe and has instituted an Environmental audit to be done monthly – see attached	7/23/07

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan L. Sloan RN, BSN, MA | TITLE: VP Operations | (X6) DATE: 7/23/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 the first floor; e. Missing globe light in the laundry room; f. Broken dryer in laundry room; g. Several unused walkers stored in the basement; h. Broken chair stored in the basement; and i. Broken vacuum cleaner stored in the basement.	W 104		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two clients in the sample. (Client #1 and Client #2) The findings include: 1. Observation of the morning medication administration on July11, 2007 at approximately	W 124	W 124 1 & 2. The facility has begun the guardianship process by completeing the following - Guardianship Questionnaire - Surrogate agreement to give consent See attached In the future the agency will ensure that all clients will have a substituted or legal guardian or entity in place for all consents for medical procedures and chemical or physical restraint procedures.	7/23/07

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W 124	Continued From page 2 8:00AM, revealed Client #1 received Loxitane 50 mg by mouth. Interview with the nursing staff on July 11, 2007 at approximately 8:01AM revealed that the medication was prescribed for behavior management. Review of the client's physicians orders dated June 1, 2007 on July 11, 2007 at approximately 10:00 AM revealed that Loxitane 50 mg by mouth twice a day and Atarax 100mg by mouth every evening was incorporated in a Behavior Support Plan (BSP) dated April 12, 2007, to address behaviors associated with physical aggression, verbal aggression, pubic disrobing, and screaming. Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 10:15AM revealed that Client #1 did not have a legal guardian. Further interview revealed that Client #1's brother signs the consents for her medical procedures, however he was not the client's legal guardian. The review of Client #1's Psychological Assessment dated April 11, 2007 on July 12, 2007 at approximately 10:45AM indicated that the client was not competent to make independent or informed decisions concerning medical and psycological treatment. There was no documented evidence that the facility informed Client #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Observation of the morning medication administration on July 11, 2007 at approximately	W 124		

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W 124	Continued From page 3 8:30AM, revealed Client #2 received Clozaril 300 mg by mouth and Loxitane 50 mg by mouth. Interview with the nursing staff on May 15, 2007 at approximately 8:31AM revealed that the medication was prescribed for behavior management. Review of the client's physicians orders dated June 1, 2007on July 11, 2007 at approximately 10:15AM revealed that Clozaril 300 mg and Loxitane 50 mg by mouth twice a day was incorporated in a corresponding BSP dated February 11, 2007, to address behaviors associated with self- injurious behavior, property destruction, physical aggression, verbal aggression, non-compliance, screaming and crying. Interview with the QMRP on July 11, 2007 at approximately 10:20AM revealed that Client #2 did not have a legal guardian. Further interview revealed that Client #2's mother signed the consents for her medical procedures, however she was not the client's legal guardian. The review of Client #2's Psychological Assessment dated February 11, 2007 on July 11, 2007 at approximately 1:50 PM indicated that the client was unable to grant informed consents in a legally competent manner regarding medical care. There was no documented evidence that the facility informed Client #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients.	W 125		

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W 125	Continued From page 4 Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that a system had been developed to inform each client, parent or legal guardian of the client's behavioral status, risk of treatment, and the right to refuse treatment for one of the two clients in the sample. (Client #1) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 10:15 AM revealed that Client #1's brother was active in her life. Review of a medical consult, dated July 5, 2007 on July, 2007 at approximately 2:50PM revealed that Client #1's brother signed the consent for a colonoscopy, however he was not the legal guardian. The review of Client #1's Psychological Assessment dated April 11, 2007 on July 12, 2007 at approximately 10:45AM indicated that the client is not competent to make independent or informed decisions concerning medical and psycological treatment. There was no evidence the client had a legally-sanctioned guardian and/or a surrogate health care decision-maker to review or approve the colonoscopy.	W 125	W 125 The facility has begun the guardianship process by completeing the following - Guardianship Questionnaire - Surrogate agreement to give consent See attached In the future the agency will ensure that all clients will have a substituted or legal guardian or entity in place for all consents for medical procedures and chemical or physical restraint procedures.	7/23/07
W 130	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS	W 130		

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W 130	Continued From page 5 The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two clients residing in the facility. (Client #1) The finding include: On July 11, 2007 at approximately 8:25 AM, Client #1 was observed sitting on the commode while the bathroom door was open. The commode and Client #1 were visible from the front door of the facility. When nursing staff entered the bathroom to assist the client, they did not close the door. Interview with nursing staff revealed that the client needed reminders to close the door when she used the bathroom. Nursing staff were not observed offering Client #1 a reminder that morning. There was no evidence that nursing staff ensured the client's privacy while using the bathroom.	W 130	W 130 The Facility has retrained all the staff, including nursing staff regarding client's rights and privacy. In the future the Agency will ensure that all staff have regular and periodic on going training in all DDS Policies and Procedures. See attached	7/23/07
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility	W 153		

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W 153	Continued From page 6 failed report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The finding includes: Review of an unusual incident report dated March 15, 2007 on July 11, 2007 at approximately 7:45 AM revealed that Client #1 complained of abdominal pain and was transported to the emergency room for evaluation and treatment. Review of an emergency room consult on July 12, 2007 at approximately 10:15 AM revealed that Client # 1 was diagnosed with constipation. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the incident was not forwarded to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.	W 153	W 153 Incident Report was faxed to DOH See attached receipt of fax. In the future the Agency will ensure that there is prompt reporting of all Incidents as required by DC Regulations. The Agency has instituted a system and has an Incident Management Unit which meets weekly to review all incidents for the preceding week. All staff, QMRP and nursing staff were retrained in Incident Management Policy and Procedures. See attached	7/23/07
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP) for two of two clients in the sample. (Client #1 and Client #2) The findings include:	W 159		

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W 159	Continued From page 7 1. Cross Refer to W153. The QMRP failed to ensure that incidents were reported that posed a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). 2. Cross Refer to W231.1 The QMRP failed to ensure that Client#1's Individual Program Plan (IPP) objectives were stated in a manner which could be quantifiably measured. 3. Cross Refer to W231.2 The QMRP failed to ensure that Client#2's Individual Program Plan (IPP) objectives were stated in a manner which could be quantifiably measured. 4. Cross Refer to W252. The QMRP failed to ensure that Client#3's Individual Program Plan (IPP) objectives were documented consistently and accurately on the the IPP data collection forms. 5. The QMRP failed to coordinate with the Psychologist to ensure that a simple token calendar program was provided for Client #2 as evidenced by: Review of Client #2's Behavioral Support Plan (BSP) dated February 11, 2007 on July 12, 2007 at approximately 12:30PM revealed a recommendation for a simple token calendar program to be posted with five blocks for each day for Client #2. Further review revealed that Client #2 could earn a star for each time period in which she did not engage in targeted behaviors (self- injurious behavior, property destruction, physical aggression, verbal aggression, non-compliance, screaming and crying). At the end of the time period, if Client #2 earned four out	W 159	W 159 1. – Cross refer to W 153 2. – Client #1's IPP has been revised to ensure that all objectives can be quantifiably measured. See attached IPP 3. - Client #2's IPP has been revised to ensure that all objectives can be quantifiably measured. See attached IPP 4. – Client #3's IPP has been revised to ensure that all objectives can be quantifiably measured. See attached 5. – The BMP for client # 2 - for the token program has been discontinued and the BMP has been amended. See attached BMP In the future the QMRP will ensure that all client programs are reviewed with the IDT at least every 6 mths to ensure that all clients receive the appropriate programs and program supplies and monitoring. The Agency has instituted a monthly QMRP Audit System to ensure that all client ISP records are reviewed monthly. See attached Audit Record	7/23/07

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W 159	Continued From page 8 of five stars she could pick out an item from a grab bag. Interview with the QMRP revealed that Client #2 did have a simple token calendar program, however no data was provided. Further interview revealed that the Psychologist did not think that the program was beneficial and a revised simple token calendar program was being developed. There was no documented evidence that Client #2 was provided with a simple token calendar program.	W 159		
W 170	483.430(b)(5) PROFESSIONAL PROGRAM SERVICES Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. This STANDARD is not met as evidenced by: Based on staff interview and record review revealed that the facility failed to ensure that one out of twelve professionals are licensed and/or certified in accordance with the District of Columbia Laws. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 3:00PM revealed that the license for the Psychiatrist was not available for review. The facility failed to have the current license available in accordance with the Health Occupation Revision Act (HORA) Title 3 Chapter 12 Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")	W 170	W 170 See attached License for Psychiatrist	7/23/07

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W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that each employee was provided with initial and continuing training that enabled the employee to perform his or her duties effectively, efficiently, and competently. The findings include: 1. Cross Refer to W153. The facility failed to ensure that staff had received effective training on reporting unusual incidents to the Department of Health (DOH). 2. Cross Refer to W192. The facility failed to ensure that staff had received effective training in implementing emergency measures . 3. Cross Refer to W194.1. The facility failed to ensure that staff demonstrated competency in recognizing signs and symptoms of illness IN Client #1 . 4. Cross Refer to W194.2. The facility failed to ensure that staff demonstrated competency in implementing fall precautions for Client #1. 5. Cross Refer to W440. The facility failed to ensure that staff had received effective training on documenting evacuation drills quarterly on all shifts.	W 189	W 189 1. Cross refer to W 153 2. All staff were trained in Emergency Protocols for - medical, non medical, Fire and Safety See attached 3. All staff were re trained in Signs and Symptoms of Illness See attached 4. All staff were re trained in Fall Precautions and Falls risk assessments and Prevention. See attached 5. All staff were re trained in Fire Evacuation drills and Fire and Safety Policy and Procedures. See attached 6. All staff were trained in Fire evacuation procedures and the QMRP and House Manager have developed a schedule for fire drills during various times and scenarios. See attached Agency will ensure that all staff receive training and periodic on going training in all DDS regulations and Policy and Procedures. The Agency is in the Process of developing a Training Dept.	7/23/07

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W 189	Continued From page 10 6. Cross Refer to W441. The facility failed to ensure that staff had received effective training on documenting evacuation drills under varied conditions.	W 189		
W 192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for four of four clients in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 11:00 AM revealed that all staff was not trained in CPR. Record review on July 12, 2007 at approximately:05 AM revealed that five out of twelve staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 2. Interview with the QMRP on July 12, 2007 at approximately 11:10 AM revealed that all staff was not trained in First Aid. Record review on July 12, 2007 at approximately 11:15 AM revealed that five out of twelve staff staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid	W 192	W 192 1 &2 – See attached CPR and First Aid certifications for current staff. Agency has instituted a computerized staff data base to monitor all personnel records on a monthly basis to ensure that on going certifications are always maintained in a current status.	7/23/07

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W 192	Continued From page 11 certifications.	W 192		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in recognizing signs and symptoms of illness and implementing fall precautions in one of two clients in the sample. (Client #1) The findings include: 1. The facility failed to effectively train staff to recognize signs and symptoms of illness in Client #1 as evidenced by: Upon entering the facility on July 11, 2007 at approximately 7:54 AM, Client #1 was observed to be screaming, crying and pointing to the second toe on her left foot. Attempts to interview Client #1 were not successful because the client continued to scream and cry. Interview with Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 on July 11, 2007 at approximately 7:55AM revealed that they had no knowledge of why Client #1 was screaming/crying and pointing to the second toe on her left foot. Further interview revealed that the direct care staff had not informed the Licensed Practical Nurse (LPN) who was in the facility that Client #1 was screaming/crying and pointing to the second toe	W 194	W 194 1 &2 – Cross refer to W 189 - #2, 3 & 4	

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W 194	Continued From page 12 on her left foot. During medication pass observation on July 11, at approximately 7:56 AM, Client #1 was observed gesturing to the LPN and pointing to the second toe on her left foot and screaming. Interview with the LPN on July 11, 2007 at approximately 8:10 AM revealed that she had assessed Client #1 and had notified the Registered Nurse (RN). Interview with the RN on July 11, 2007 at approximately 9:30AM revealed that the LPN had notified her via telephone that Client #1 was pointing to the second toe on her left foot and screaming. Further interview with the RN revealed that she had notified the Primary Care Physician (PCP) at approximately 8:20AM concerning Client #1 and that Motrin 600mg by mouth three times a day had been ordered for pain. Further interview revealed that the RN had assessed that the nailbeds around Client #1's left and right second toe were slightly red and that she would continue to monitor Client #1. [Note: Observation and interview with the Registered Nurse (RN)on July 11, 2007 at approximately 5:00PM revealed that Direct Care Staff #1, Direct Care Staff#2 and Direct Care Staff #3 participated in an in-service training on signs and symptoms of illness on July 12, 2007] 2. The facility failed to effectively train staff to implement fall precautions for Client #1 as evidenced by: Client #1 was observed to inform the House Manager on July 11, 2007 at approximately 9:00AM that she had fallen in her bedroom that night and that she had informed Direct Care Staff #1. The House Manager was observed to immediately call Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 and inform	W 194		

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W 194	Continued From page 13 them that she was conducting an investigation regarding Client #1's allegation of haven fallen on the night of July 11, 2007. Further observation revealed that the House Manager documented the incident and began to notify the designated officials per facility policy. Interview with the RN on July 11, 2007 at approximately 3:00 PM revealed that the PCP ordered bi-lateral hip and leg x-rays for Client #1 and she was transported to the emergency room via the facility van. Review of Client #1's medical assessment dated April 11, 2007 on July 12, 2007 at approximately 10:28AM revealed that the client had a diagnosis of osteoporosis. Review of Client #1's Health Management Care Plan dated April 22, 2007 on July 12, 2007 at approximately 10:51AM revealed that the client had fall precautions documented as a risk area. Review of the radiology reports dated July 11, 2007 on July 12, 2007 at approximately 2:30PM revealed that Client #1 had not sustained any bi-lateral hip or leg fractures. [Note: Observation and interview with the RN on July 11, 2007 at approximately 5:00PM revealed that Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 participated in an in-service training on fall precautions on July 11, 2007]	W 194		
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that all client program objectives were formulated to provide measurable indices of	W 231		

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W 231	Continued From page 14 performance for two of two clients in the sample. (Client #1 and Client #2) The findings include: 1. Review of Client #1's Individual Program Plan (IPP) dated May, June and July 2007 on July 12, 2007 at approximately 1:45 PM included the following money management objective: Take item receipt, take change and take item with verbal prompt. In an interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 1:50PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provide measurable indices of performance at each level. 2. Review of Client #2's Individual Program Plan (IPP) dated May, June and July 2007 on July 12, 2007 at approximately 1:55 PM included the following money management objective: Take item receipt, take change and take item with verbal prompt. In an interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 2:00PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provide measurable indices of performance at each level.	W 231	W 231 1. Client #1 has had her IPP for money management revised to provide measurable indices– see attached 2. Client #2 has had her IPP revised to ensure the objectives are measurable. See attached All staff have been in serviced on the new programs and documentation See attached	7/23/07
W 252	483.440(e)(1) PROGRAM DOCUMENTATION	W 252		

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W 252	Continued From page 15 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives are documented consistently and accurately for one of the two clients included in the sample. (Client #2) The finding includes: Review of Client #2's had a Individual Program Plan (IPP) dated February 8, 2007 on July 12, 2007 at approximately 2:30PM revealed that Client #2 had a goal to improve lower extremity strength. Further review revealed that if the client is not able to complete task put a minus in the box for the date and document in the comment section how much the client accomplished. Review of the IPP data collection on July 12, 2007 at approximately 2:35PM revealed that that the staff had not documented in accordance with the instructions. The data collected was documented as follows: a) June 4, 6, 8, 15, 22, 25 and 29, 2007- There was no evidence that the staff documented in the comment section how much the client accomplished when a minus was placed in the boxes for the specified dates. b) July 4 and 11, 2007- Staff documented "did not complete the task" in the comment section for	W 252	W 252 Client #2 – program for improving lower extremity strength. All staff have been in serviced on documentation, to ensure that accurate comments are documented to signify the actual number of accomplished tasks, so that an accurate assessment can be made of the client's progress. See attached	7/23/07

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W 252	Continued From page 16 the specified dates. In an interview with the Qualified Mental Retardation Professional (QMRP)on July 12, 2007 at approximately 2:40 PM, it was acknowledged that the staff were implementing the program as written but that there was a problem with the documentation. There was no evidence that the data had been collected in accordance with the IPP for Client #2, which was necessary for a functional assessment of the client's progress.	W 252		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to failed to provide preventive and general care and failed to implement medical protocols for one of two clients in the sample (Client #2) The finding includes: 1. The facility's medical services failed to prescribe glucose monitoring perimeters for Client #2 as evidenced by: Interview with the Licensed Practical Nurse (LPN) on July 11, 2007 at approximately 2:30PM, revealed that Client #2 has a diagnosis of Borderline Diabetes Mellitus and that blood glucose measurement utilizing a glucometer is prescribed three times a week. Further interview	W 322	W 322 1. The parameters for blood glucose monitoring have been included on the POS. See attached 2. Endocrinology appointment has been scheduled 3. Blood work has been scheduled. The agency has instituted a Medical Activity Record to monitor clients' medical follow up. The medical records are reviewed monthly by the RN Supervisor and the agency has instituted a Quarterly QA system to monitor client health services. See attached	7/23/07

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W 322	Continued From page 17 revealed that the Primary Care Physician (PCP) did not indicate any blood glucose measurement perimeters. Review of the Client #2's physician's orders dated June 1, 200 on July 11, 20077 at approximately 2:35 PM revealed that blood glucose measurement perimeters were not prescribed for Client#2. There was no evidence that blood glucose measurement perimeters prescribed by the PCP. 2. Cross Refer to W331. The facility's nursing services failed to obtain a timely endocrinology appointment for Client # 2. 3. Cross Refer to W331. The facility's nursing services failed to obtain timely laboratory studies for Client # 2 as recommended by the Endocrinologist.	W 322		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of two clients in the sample. (Client # 2) The findings include: 1. The facility's nursing services failed to ensure that Client #2 returned to the endocrinology clinic as recommended as evidenced by: Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:00PM revealed that Client #2 was recommended to	W 331	W 331 1&2 - Cross refer to W 322	

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W 331	Continued From page 18 return to the endocrinology clinic in four months. In an interview with Licensed Practical Nurse (LPN) on July 12, 2007 at approximately 1:08 PM it was acknowledged that Client #2 did not return to the endocrine clinic in four months. There was no documented evidence that Client #2 returned to the endocrinology clinic in four months as recommended by the endocrinologist. [Note: Interview with the LPN on July 12, 2007 at approximately 1:15PM revealed that Client #2 was being scheduled for an endocrinology appointment on August 20, 2007] 2. The facility's nursing services failed to obtain timely laboratory studies for Client # 2 as recommended by the Endocrinologist as evidenced by: Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:02PM revealed that Client #2 was recommended to have a Hemoglobin AIC laboratory study performed in four months. In an interview with Licensed Practical Nurse (LPN) on July 12, 2007 at approximately 1:09 PM it was acknowledged that Client #2 did not have a Hemoglobin AIC laboratory study performed in four months. There was no documented evidence that Client #2 had a Hemoglobin AIC laboratory study performed in four months as recommended by the endocrinologist [Note: Interview with the LPN on July 12, 2007 at approximately 1:20 PM revealed that Client #2 was being scheduled for a Hemoglobin AIC laboratory study on August 15, 2007]	W 331		
W 393	483.460(n)(1) LABORATORY SERVICES	W 393		

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W 393	Continued From page 19 If a facility chooses to provide laboratory services, the laboratory must meet the requirements specified in part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it met the requirements for performing glucose monitoring testing for one of one clients who requires glucose testing. (Client #2) The finding includes: Interview with the Licensed Practical Nurse (LPN) on July 11, 2007 at approximately 2:30PM, revealed that Client #2 has a diagnosis of Borderline Diabetes Mellitus and is prescribed Glucophage 500mg every evening. Interview with the LPN revealed that blood glucose measurements utilizing a glucometer is prescribed three times a week. Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007, at 3:00 P.M. revealed that the provider does not have a certificate of waiver as required by part 493 of the Clinical Laboratory improvement Act (CLIA). Review of the Client #2's Medication Administration Record (MAR) on July 11, 2007 at approximately 3:10PM revealed that Client#2 is prescribed finger sticks to monitor her glucose levels three times a week. [Note: The facility was referred to the Department of Health (DOH)laboratory surveyor for an application review on July 11, 2007 at 3:20 P.M.]	W 393	W 393 The agency has started the process for meeting the requirements to provide laboratory services See attached	7/29/07
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least	W 440		

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W 440	Continued From page 20 quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review, the facility failed to hold evacuation drills quarterly on all shifts. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 10:30AM revealed that the staff schedules are as follows: Day shift: 8:00 AM- till clients go to day program Evening shift: 4:00 PM to 12:00 PM Night shift: 12:00 PM to 8:00 AM Review of the available fire drill records dated from August 2007 to June , 2007 on July 11, 2007 at approximately 10:35 AM revealed that fire drills were not conducted on the day shift during the first quarter. There was no evidence that every shift of personnel conducted an evacuation drill at least quarterly.	W 440	W 440 Cross refer to W 189 – 5&6	
W 441	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on staff interview and record verification, the facility failed to hold evacuation drills under varied conditions. The finding includes: On July 11, 2007 at approximately 10:45AM	W 441	W 441 Facility has developed a schedule to include varying times and scenarios to include evacuation via all available egresses. The staff was in serviced on proper conduction of Fire drills and accurate documentation. The Agency has instituted a monthly Environmental and QMRP QA system – to ensure the appropriate Policy and Procedures are followed. See attached	7/23/07

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W 441	Continued From page 21 review of fire drill records and interview with the Qualified Mental Retardation Professional (QMRP)revealed that during the past year, staff had not practiced exiting through all four egresess of the facility. Most fire drills were conducted via the front exits. There was no evidence that evacuation drills were being held under varied conditions.	W 441		

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I 000	INITIAL COMMENTS A licensure survey was conducted from July 11, 2007 through July 12, 2007. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a resident population of four females with various disabilities. The survey findings were based on observations in the group home and one day program, and interviews with residents, residential, day program, nursing and administrative staff. Review of records, including investigations of unusual incidents was also conducted.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observations, interviews and review of records, the facility's governing body provided general operating direction over the facility, except in the following areas: The finding includes: The governing body failed to ensure the maintenance of the facility's environment, as evidenced by: a. Front door bell alarm button loose; b. Back bedroom door bell alarm button loose; c. Missing towel bar in the first bathroom on the	I 090	I 090 Refer to W 104	

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I 180	Continued From page 3 4. Cross Refer to W252. The QMRP failed to ensure that Resident #3's Individual Program Plan (IPP) objectives were documented consistently and accurately on the the IPP data collection forms. 5. The QMRP failed to coordinate with the Psychologist to ensure that a simple token calendar program was provided for Resident #2 as evidenced by: Review of Resident #2's Behavioral Support Plan (BSP) dated February 11, 2007 on July 12, 2007 at approximately 12:30PM revealed a recommendation for a simple token calendar program to be posted with five blocks for each day for Resident #2. Further review revealed that Resident #2 could earn a star for each time period in which she did not engage in targeted behaviors (self- injurious behavior, property destruction, physical aggression, verbal aggression, non-compliance, screaming and crying). At the end of the time period, if Resident #2 earned four out of five stars she could pick out an item from a grab bag. Interview with the QMRP revealed that Resident #2 did have a simple token calendar program, however no data was provided. Further interview revealed that the Psychologist did not think that the program was beneficial and a revised simple token calendar program was being developed. There was no documented evidence that Resident#2 was provided with a simple token calendar program.	I 180		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status	I 206		

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I 206	Continued From page 4 would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file. The finding includes: Review of personnel records on July 12, 2007 at approximately 11:05 AM revealed no documented evidence of current health certificates for five direct staff members [redacted], Pharmacist, Psychiatrist and Psychologist consultants. In an interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 2:50PM it was acknowledged that the health certifications were not available during the survey.	I 206	I 206 See attached health certificates for [redacted], [redacted], [redacted], [redacted] and [redacted] Agency has instituted a computerized staff data base to monitor all personnel records on a monthly basis to ensure that on going certifications / records are maintained in a current status.	7/23/07
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to recognize signs and symptoms of illness and fall precautions in one of two residents in the sample (Resident #1) and to implement emergency measures for four of four residents in the facility. (Residents #1, #2, #3 and #4)	I 227	I 227 Cross refer to W 192	

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I 227	Continued From page 5 The findings include: 1. Interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 11:00 AM revealed that all staff was not trained in CPR. Record review on July 12, 2007 at approximately:05 AM revealed that five out of twelve staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 2. Interview with the QMRP on July 12, 2007 at approximately 11:10 AM revealed that all staff was not trained in First Aid. Record review on July 12, 2007 at approximately 11:15 AM revealed that five out of twelve staff staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications.	I 227	I 227 Cross refer to W 192	
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in recognizing signs and symptoms of illness and implementing fall	I 229	I 229 Cross refer to W 189 #4	

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I 229	Continued From page 6 precautions in one of two clients in the sample. Resident #1 The findings include: 1. The facility failed to effectively train staff to recognize signs and symptoms of illness in Resident #1 as evidenced by: Upon entering thre facility on July 11, 2007 at approximately 7:54AM, Resident #1 was observed to be screaming and crying and pointing to the second toe on her left foot. Attempts to interview Resident #1 were not successful because the client continued to scream and cry. Interview with Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 on July 11, 2007 at approximately 7:55AM revealed that they had no knowledge of why Resident #1 was screaming/crying and pointing to the second toe on her left foot. Further interview revealed that the direct care staff had not informed the Licensed Practical Nurse (LPN) who was in the facility that Resident #1 was screaming/crying and pointing to the second toe on her left foot. During medication pass observation on July 11, at approximately 7:56 AM, Resident #1 was observed gesturing to the LPN and pointing to the second toe on her left foot and screaming. Interview with the LPN on July 11, 2007 at approximately 8:10 AM revealed that she had assessed Client #1 and had notified the Registered Nurse (RN). Interview with the RN on July 11, 2007 at approximately 9:30AM revealed that the LPN had notified her via telephone that Client #1 was pointing to the second toe on her left foot and screaming.Further interview with the RN revealed that she had notified the Primary Care Physician (PCP) at	I 229		

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I 229	Continued From page 7 approximately 8:20AM concerning Client #1 and that Motrin 600mg by mouth three times a day had been ordered for pain. Further interview revealed that the RN had assessed that the nailbeds around Client #1's left and right second toe were slightly red and that she would continue to monitor Client #1. [Note: Observation and interview with the RN on July 11, 2007 at approximately 5:00PM revealed that Direct Care Staff #1, Direct Care Staff#2 and Direct Care Staff #3 participated in an in-service training on signs and symptoms of illness on July 12, 2007] 2. The facility failed to effectively train staff to implement fall precautions for Resident #1 as evidenced by: Resident #1 was observed to inform the House Manager on July 11, 2007 at approximately 9:00AM that she had fallen in her bedroom that night and that she had informed Direct Care Staff #1. The House Manager was observed to immediately call Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 and inform them that she was conducting an investigation regarding Resident #1's allegation of haven fallen on the night of July 11, 2007. Further observation revealed that the House Manager documented the incident and began to notify the designated officials. Interview with the RN on July 11, 2007 at approximately 3:00PM revealed that the PCP ordered bi-lateral hip and leg x-rays for Resident #1 and she was transported to the emerency room via the facility van. Review of Resident #1's medical assessment dated April 11, 2007 on July 12, 2007 at approximately 10:28AM revealed that the client has a diagnosis of osteoporosis. Review of Resident #1's Health Management	I 229		

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I 229	Continued From page 8 Care Plan dated April 22, 2007 on July 12, 2007 at approximately 10:51AM revealed that the client has fall precautions documented as a risk area. Review of the radiology reports dated July 11, 2007 on July 12, 2007 at approximately 2:30PM revealed that Resident #1 had not sustained any fractures. [Note: Observation and interview with the RN on July 11, 2007 at approximately 5:00PM revealed that Direct Care Staff #1, Direct Care Staff #2 and Direct Care Staff #3 participated in an in-service training on fall precautions on July 11, 2007]	I 229		
I 370	3519.1 EMERGENCIES Each GHMRP shall maintain written policies and procedures which address emergency situations, including fire or general disaster, missing persons, serious illness or trauma, and death. This Statute is not met as evidenced by: Based on interview and record review, the facilty failed report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The finding includes: Review of an unusual incident report dated March 15, 2007 on July 11, 2007 at approximately 7:45 AM revealed that Resident #1 complained of abdominal pain and was transported to the emerency room for evaluation and treatment. Review of an emerency room consult on July 12, 2007 at approximately 10:15 AM revealed that Resident # 1 was diagnosed with constipation. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that the incident	I 370	I 370 Cross refer to W 153	

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I 370	Continued From page 9 was not forwarded to the Department of Health (DOH). There was no documented evidence that this incident had been reported to governmental agencies as required.	I 370		
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to failed to provide preventive and general care and failed to implement medical protocols for one of two residents in the sample (Resident #2) The finding includes: 1. The facility's medical services failed to prescribe glucose monitoring perimeters for Resident #2 as evidenced by: Interview with the Licensed Practical Nurse (LPN) on July 11, 2007 at approximately 2:30PM, revealed that Resident#2 has a diagnosis of Borderline Diabetes Mellitus and that blood glucose measurement utilizing a glucometer is	I 391	I 391 Cross refer to W 322	

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I 391	Continued From page 10 prescribed three times a week. Further interview revealed that the Primary Care Physican (PCP) did not indicate any blood glucose measurement perimeters. Review of the Resident#2's physician's orders dated June 1, 200 on July 11, 20077 at approximately 2:35 PM revealed that blood glucose measurement perimeters were not perscribed for Resident #2. There was no evidence that blood glucose measurement perimeters perscribed by the PCP. 2. Cross Refer to W331. The facility's nursing services failed to obtain a timely endocrinology appointment for Resident# 2. 3. Cross Refer to W331. The facility's nursing services failed to obtain timely laboratory studies for Resident #2	I 391		
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (e) Nursing; This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of one of two	I 395	I 395 Cross refer to W 322	

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I 395	Continued From page 11 residents in the sample. (Resident # 2) The findings include: 1. The facility's nursing services failed to ensure that Resident #2 returned to the endocrinology clinic as recommended as evidenced by: Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:00PM revealed that Resident #2 was recommended to return to the endocrinology clinic in four months. In an interview with Licensed Practical Nurse (LPN) on July 12, 2007 at approximately 1:08 PM it was acknowledged that Resident #2 did not return to the endocrine clinic in four months. There was no documented evidence that Resident #2 returned to the endocrinology clinic in four months as recommended by the endocrinologist. [Note: Interview with the LPN on July 12, 2007 at approximately 1:15PM revealed that Resident #2 was being scheduled for an endocrinology appointment on August 20, 2007] 2. The facility's nursing services failed to obtain timely laboratory studies for Resident # 2 as recommended by the Endocrinologist as evidenced by: Review of an endocrine consult dated February 2, 2007 on July 12, 2007 at approximately 1:02PM revealed that Resident #2 was recommended to have a Hemoglobin AIC laboratory study performed in four months. In an interview with Licensed Practical Nurse (LPN) on July 12, 2007 at approximately 1:09 PM it was acknowledged that Resident #2 did not have a Hemoglobin AIC	I 395		

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I 395	Continued From page 12 laboratory study performed in four months. There was no documented evidence that Resident #2 had a Hemoglobin AIC laboratory study performed in four months as recommended by the endocrinologist [Note: Interview with the LPN on July 12, 2007 at approximately 1:20 PM revealed that Resident #2 was being scheduled for a Hemoglobin AIC laboratory study on August 15, 2007]	I 395		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation and interview, the failed to ensure privacy was provided during care of personal needs for one of two residents residing in the facility. (Resident #1) The finding include: On July 11, 2007 at approximately 7:55 AM, Resident #1 was observed sitting on the commode while the bathroom door was open. The commode and Resident #1 were visible from the front door of the facility. When nursing staff entered the bathroom to assist the client, they did not close the door. Interview with nursing staff revealed that the resident needed reminders to close the door when she used the bathroom. Nursing staff were not observed offering Resident	I 436	I 436 Refer to W 130	

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I 436	Continued From page 13 #1 a reminder that morning. There was no evidence that nursing staff ensured the resident's privacy while using the bathroom.	I 436		
I 442	3521.7(l) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (l) Time management (including use of leisure time, scheduling activities); This Statute is not met as evidenced by: Based on interview and record review the facility failed to ensure that all resident program objectives were formulated to provide measurable indices of performance for two of two residents in the sample. (Resident #1 and Resident #2) The findings include: 1. Review of Resident #1's Individual Program Plan (IPP) dated May, June and July 2007 on July 12, 2007 at approximately 1:45 PM included the following money management objective: Take item receipt, take change and take item with verbal prompt. In an interview with the Qualified Mental Retardation Professional (QMRP) on July 12, 2007 at approximately 1:50 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provide measurable indices of performance at each level.	I 442	I 442 Cross refer to W 153 & W 159	

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I 442	Continued From page 14 2. Review of Resident #2's Individual Program Plan (IPP) dated May, June and July 2007 on July 12, 2007 at approximately 1:55 PM included the following money management objective: Take item receipt, take change and take item with verbal prompt. In an interview with the QMRP on July 12, 2007 at approximately 2:00 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provide measurable indices of performance at each level.	I 442		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record verification, the facility failed to ensure the right of each resident or their legal guardian to be informed of the resident's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of two residents in the sample. (Resident #1 and Resident #2) The findings include: 1. Observation of the morning medication administration on July 11, 2007 at approximately 8:00AM, revealed Resident #1 received Loxitane 50 mg by mouth. Interview with the nursing staff	I 500	I 500 Cross refer to W 124 & 125	

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I 500	Continued From page 15 on July 11, 2007 at approximately 8:01AM revealed that the medication was prescribed for behavior management. Review of the resident's physicians orders dated June 1, 2007 on July 11, 2007 at approximately 10:00 AM revealed that Loxitane 50 mg by mouth twice a day and Atarax 100mg by mouth every evening was incorporated in a Behavior Support Plan (BSP) dated April 12, 2007, to address behaviors associated with physical aggression, verbal aggression, pubic disrobing, and screaming. Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 10:15AM revealed that Resident #1 did not have a legal guardian. Further interview revealed that Resident #1's brother signs the consents for her medical procedures, however he is not the client's legal guardian. The review of Resident #1's Psychological Assessment dated April 11, 2007 on July 12, 2007 at approximately 10:45AM indicated that the resident is not competent to make independant or informed decisions concerning medical and psycological treatment. There was no documented evidence that the facility informed Resident #1 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Observation of the morning medication administration on July 11, 2007 at approximately 8:30AM, revealed Resident #2 received Clozaril 300 mg by mouth and Loxitane 50 mg by mouth. Interview with the nursing staff on May 15, 2007 at approximately 8:31AM revealed that the medication was prescribed for behavior	I 500		

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I 500	Continued From page 16 management. Review of the resident's physicians orders dated June 1, 2007on July 11, 2007 at approximately 10:15AM revealed that Clozaril 300 mg and Loxitane 50 mg by mouth twice a day was incorporated in a corresponding BSP dated February 11, 2007, to address behaviors associated with self- injurious behavior, property destruction, physcial aggression, verbal aggression, non- compliance,sreaming and crying. Interview with the QMRP on July 11, 2007 at approximately 10:20AM revealed that Resident #2 did not have a legal guardian. Further interview revealed that Resident #2's mother signs the consents for her medical procedures, however she is not the client's legal guardian. The review of Resident #2's Psychological Assessment dated February 11, 2007 on July 11, 2007 at approximately 1:50 PM indicated that she is unable to grant informed consents in a legall competant manner regarding medical care. There was no documented evidence that the facility informed Resident #2 or a legally-authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 3. Interview with the Qualified Mental Retardation Professional (QMRP) on July 11, 2007 at approximately 10:15 AM revealed that Client #1's brother was active in her life. Review of a medical consult, dated July 5, 2007 on July, 2007 at approximately 2:50PM revealed that Client #1's brother signed the consent for a colonoscopy, however he was not the legal guardian. The review of Client #1's Psychological Assessment dated April 11, 2007 on July 12,	I 500		

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I 500	Continued From page 17 2007 at approximately 10:45AM indicated that the client is not competent to make independant or informed decisions concerning medical and psycological treatment. There was no evidence the client had a legally-sanctioned guardian and/or a surrogate health care decision-maker to review or approve the colonoscopy.	I 500		